Scenarios for the future of mental health care: a social perspective

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Summary

Social values and social concepts have played a central role in the history of mental health care. They have driven major reforms and guided the development of various treatment models. Whilst the 'social' has been important in the past, this study addressed what its role might be in the future. We (DG, PH, SP) conducted a survey of professional stakeholders and then used a scenario planning technique in an international expert workshop. The workshop developed four distinct but not mutually exclusive scenarios, in which the social is central: mental health care will be patient-controlled; mental health care will target people's social context to improve their mental health; mental health care will become virtual; access to care will be regulated based on social disadvantage. These scenarios are not intended as fixed depictions of what will happen. They may however be useful in guiding further debate, research and innovation.

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Introduction

Social values and concepts – reflecting a wide understanding of a social paradigm - have played a central role in the history of mental health care.[1-2] They were essential for the origins of modern psychiatry during the Age of Enlightenment,[3] drove major reforms of care and de-institutionalisation in the 20th century, and led to various treatments, including models of family and group therapies, and a range of community based services.[1] The extent to which the social has been considered important in mental health care has varied over time. It has been argued that, over the last 40 years, it has become less prominent, at least in academic psychiatry.[4]

This leads to the question: what does a social paradigm have to offer for the future of mental health care? Can a renewed focus on the social open up perspectives for innovation, i.e. for developments that are distinct from current practice and go beyond what has already been established?

Any attempt to envisage options for future mental health care needs to consider the changing technological, economic, social and political context.[5-6] This inevitably entails speculation. It is impossible to anticipate with certainty how all these factors will change in the future, but they are likely to affect how people live and how mental health care can and will operate.

Against this background, we (DG, SP) conducted a project to explore the potential future of the social in mental health care. The envisaged time scale covered the next 20 years, and the explicit focus was on care, i.e. on what support and treatment societies might provide to help people overcome mental distress and what role professional services may play within this. Rather than trying to come up with accurate or most likely predictions for what will happen, we set out to develop different and not mutually exclusive scenarios. Each scenario aimed to elaborate one specific idea for how the future may develop. Thus, we did not seek a consensus, but envisaged different scenarios and their potential impact on mental health care in the future.

The method of scenario planning is typically carried out by a group of experts who consider the 'instabilities' of the present and the 'drivers for change', and then imagine plausible different future scenarios.[7] Instabilities are issues within a specific field, in this case mental health care, that are likely to change in the future as they are currently problematic. Drivers for change are factors that may determine the future of the field, but are external. Thus, they are not directly related to the organisational, clinical and academic facets of mental health care itself, but are determined by more general societal changes. The project was limited to Western Europe to provide sufficient focus and avoid overloading the debate with too much complexity.

The instabilities and drivers for change in mental health care were first suggested during a survey of professionals. The survey findings were presented and discussed at the beginning of a workshop with experts from different European countries. During the workshop, the survey findings were refined and complemented. Inclusion did not require endorsement by the whole group. Informed by the discussion about instabilities and drivers for change, the workshop then developed potential scenarios for the future. The methods of survey and workshop are described in more detail in the appendix.

Four possible scenarios were identified: *'patient controlled service'*, mental health care will be patient-led and without coercion; *'modifying social contexts'*, care will target people's social and living contexts to improve their mental health; *'virtual mental health care'*, care will be provided primarily on-line and become virtual; *and 'partners to the poor'*, access to and provision of care will be regulated based on social disadvantage.

Patient-controlled services

Patients would play a leading role in the planning of all mental health care. Services would be designed by patients and provided in response to their requests and preferences. Treatment decisions, including admissions to hospital and referrals to specific therapies, would be controlled by patients. Coercive measures, including both formal and informal types of coercion, would not be part of mental health care provision.

Resources would be used to fund co-developed services based on the entitlements and rights of patients. In these services, the main role of professionals would be to advocate for patients' rights on a societal level and respond to patients' preferences on a personal level. Their main function when in contact with individual patients would be to assist them, providing expertise and to be available, if and when support or medical interventions are requested.

Peer workers would be members or leaders of all mental health services, and service culture would be based on patient and carer involvement at all levels, i.e. planning, provision and evaluation of care. Personal budgets would be the main form of care funding, and the focus of services would be on patient capacity building instead of capacity and risk assessment. Response to threats of violence and actual violence would be the remit exclusively of the criminal justice system, following the same legislative framework as for anyone else in society. Consequently, offenders with mental disorders would be sent to prisons rather than hospitals.

Such a focus would have implications for research and the training of mental health professionals. Mental health research would be more determined by patients, taking into

account their understanding and experience of care, and producing information that patients request to inform their decisions on how to make best use of services and treatments.

Mental health professionals would develop skills to engage with communities to advocate for patients, and with patients to fulfil their new role. They would be trained to assist and support patients in order to help them achieve their goals, and take no responsibility for patients' decisions. As a consequence, psychiatrists and other mental health professionals might or might not lose part of their status and overall funding for professional mental health care might be reduced.

Modifying social contexts

Mental health services would provide interventions aimed at modifying the social context of people who are experiencing psychological distress. These interventions could include support with parenting, the provision of educational and occupational opportunities, and initiatives for social activities and relationship building within local communities.

Implementing such interventions would be part of the role of psychiatrists and other mental health professionals. People who are likely to benefit could either self-refer to services or be identified through data at a community level. Continuous data collection (data cycles) on people exposed to the interventions would be needed to monitor the creation (or dissolution) of "toxic" or unhelpful social determinants and the effect of this on mental health. If mental health services take an active role with regard to the social aspects of peoples' lives, there would be very close collaboration – or even amalgamation - with social services and local authorities.

If social contexts are modified, this would often affect not only individuals with mental distress, but whole families and communities as well. Targets and outcomes of interventions would be discussed in consultation with stakeholders, including patients and their families, and the general public.

With respect to research, there would be investment in understanding how social factors and interactions could have a beneficial effect on mental health and how to facilitate this. Collaboration with social scientists would be key.

Mental health training would include significant contributions from the social sciences, including community psychology and geography, and of partners from local authorities and social services. Accurate methods for testing change in social relationships would have to be developed and all professionals would be trained to use at least some of them.

Virtual mental health care

All mental health care, with the potential exception of emergency care, would be provided online and by virtual mental health professionals.

The virtual professional would not be a human being, but an avatar with artificial intelligence. It would be reliable, always available, and equipped with the best information on evidence-based interventions. It would never forget anything the patient has ever said,

and be able to communicate in any style that the patient might prefer. Patients would be able to choose gender, age, ethnic group, appearance and other characteristics of the virtual professional. The software to make this possible could be developed based on best available mental health care expertise and evidence and it would provide data for consistent quality improvement.

This form of care would be available all over the world, would not require any professionals for local services, and would therefore cost very little. It would be eco-friendly as there would be no need to travel to access mental health care appointments. Patients might also wish to present themselves with different characteristics as different 'virtual' patients to different virtual professionals. Drones might be used to deliver medications, and patients might even be able to give a physical body to their virtual clinicians in the form of a robot.

Some patients might still want some contact with real humans to supervise or validate their interactions with the virtual clinicians. The software developer might need to take responsibility for malpractice and have the power to charge costs for access to clinical services.

Research would be mainly focused on the quality improvement of software programmes utilising process and outcome data.

There might be human facilitators to help patients navigate the software. Yet, the human workforce actively providing mental health care would be drastically reduced as well as the need for training in mental health care provision.

Partners to the poor

Mental health care would be part of a holistic service for people who experience social disadvantage. There would be a single unified access point to services based on social disadvantage criteria. Social disadvantage cut-offs would be defined according to dimensions such as poverty, social isolation, homelessness, unemployment, marginalisation, discrimination, and other more specific aspects such as forced migration.

There would be no clear distinction between physical, psychological and social distress and care. All assessments would be comprehensive and adopt a generic approach, mainly aimed at understanding the social context in which the conditions are developed. Pharmacological or specific psychotherapeutic interventions would be applied and evaluated taking into account the social context.

On a societal level, this would require advocacy for socially disadvantaged groups, and calls for political decisions aimed at reducing social disadvantage. At a community level, services would try to target risk factors for social disadvantage and health disorders. Specific services for socially disadvantaged families might be set up. Care would be provided via face-to-face interactions and require co-location of services for physical and mental health care and social services.

Research would focus more on social factors determining both physical and mental disorders and on overall care provision. Attention to evidence and interventions focused on social determinants of health would increase.

Most professionals would receive non-specialised training in physical and mental disorders, whilst specialist professionals might be fewer and work in a smaller number of services.

Discussion

The four scenarios are presented with a large degree of speculation about what their implications might be, and without addressing the likelihood and desirability of each scenario. If one of the proposed scenarios materialised substantially, the other scenarios might be less relevant. However, it seems more likely that each of these different scenarios could develop to differing extents, in which case certain aspects of the different scenarios might co-exist.

Although the scenarios are based on very different ideas, all share an emphasis on the social. They consider the importance of understanding a person's social context and acting upon and within that. Each scenario would entail fundamental changes to current practice and require more or less dramatic re-organisation of services. The roles and work of professionals would be different. Across the different scenarios, today's professions would either mostly disappear, being replaced by peer support workers or artificial intelligence, or take on different roles as social advocates or assistants to patients.

How mental health services would collaborate with other agencies varies across the different scenarios. Two scenarios would involve strengthening the links with local authorities and social services or with physical health services. Other scenarios require incorporating virtual world expertise in designing mental health care models or having a more explicit and comprehensive model for stakeholders' involvement in mental health care with no use of formal or informal coercion.

Common to different scenarios is the relevance of stakeholder involvement. Patients, their families, and members of the general public play an important part in the transformation of mental health services in all imagined future scenarios. Their potential roles range from a leading position in designing and operating mental health services to a consulting and monitoring role in the application of social intervention models in practice.

At the core of the scenarios is the question of where the expertise for mental distress and mental health care lies. The scenarios provide different responses to this. One of them bases mental health care expertise on patients' lived experience and on their preferences. Other scenarios involve a holistic model for health and social care or aim to incorporate insights from social sciences or community psychology more formally in mental health research and training curricula.

The different scenarios have more or less likely features and persuasive aspects. Their appeal will vary, depending on the underlying values, ideals and concepts one has for mental health care specifically or even for societal life in general. Yet, each of them has some potential to develop in reality, either as indicated in this paper or in different forms. The scenarios were developed by a selected group of professionals with expertise in mental health care, who were all from Europe and may have been influenced by a shared background of working in relatively well-resourced institutions. Future projects may assess the views of professionals with other expertise, patients, their families and further stakeholders on these and potentially other scenarios. Also, similar projects may be conducted for areas other than Western Europe.

Considering such scenarios, as well as alternative ones, enables professionals to participate pro-actively in influencing and shaping the future of mental health care. This might be achieved through new theories, research, service development, training for new roles and/or political action. In any case, one may hope that mental health care will benefit from a lively debate about its future, identifying and addressing different visions and ideas.

Conflict of interest
TC is president of the World Association for Social Psychiatry - an organisation that promotes the importance of the 'social' in psychiatry. PH has received personal fees from Unit for Social & Community Psychiatry, WHO Collaborating Centre for Mental Health Services Development, to support his participation in the study and to facilitate the workshop. The other authors declare no conflicts of interest.

Contributors
DG and SP have developed the project protocol and organised the survey and the workshop. DG and PH analysed data from the survey. DG and SP prepared a first draft of the manuscript.
MA, VB, TC, GD, JG, SGG, TG, PH, SJ, NJ, RL, CM, MM, GS, MZ and SW participated in the workshop, provided active contribution to the analysis of survey findings and development of scenarios and approved the final draft.

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Panel. Instabilities and drivers for the future in mental health care

Instabilities

- Biological research has a dominant status in academia.
- Funding for social research is lacking.
- Patients and their family members/friends (informal carers) need to be more strongly involved in care.
- More collaboration with other agencies on social aspects of care (e.g. primary care, social services, local authorities) is required.
- Stronger theories and methods on the impact of social factors on mental health are needed.
- Achieving change in social factors is difficult.
- Effective and more affordable social interventions for mental health care need to be developed.
- Translating knowledge into clinical practice and mental health policies is challenging.
- There are significant problems with recruitment of mental health care professionals.
- Patients have increased access to care information via the internet.
- Keeping up with changes in cultural norms is a challenge.
- Implementing a multidisciplinary approach can be problematic.
- Preventive strategies are lacking.

Drivers for change

- Increasing social inequalities and injustice
- Ageing population
- Reduced role of families
- Digital age
- Increasing loneliness and social isolation
- Privatisation of mental health care
- Increasing urbanisation
- Globalisation
- Mass migration
- Increasing individualism
- UN Convention on the Rights of People with Disabilities

Appendix

Methods and participants

Instabilities and drivers for change were identified through: a) a survey eliciting the views of a range of professionals in mental health research and care; b) a workshop with a core group of 18 international experts (the authors of this paper). The final scenarios presented in this paper were put forward and shaped during the workshop.

Survey

The survey was conducted online and disseminated through different networks with the help of the World Association for Social Psychiatry, the Early Career Psychiatrists' Committee of the European Federation of Psychiatric Trainees and via the personal networks of the project organisers (DG and SP). The contacts reached by the survey included academic and clinical psychiatrists, research and clinical psychologists, social scientists and social workers.

Participating in the survey was voluntary with no incentives provided. The survey included open-ended questions on the future of the social in mental health care covering: a) challenges; b) role change, if any; c) tasks and d) priorities for the field. The complete list of questions were:

A. What have been the most important insights that research on the 'social' in mental health care has produced? (please name three)
B. What have been the most important improvements regarding the 'social' in the practice of mental health care? (please name three)
C. What will be the most important changes in society in the next 20 years that will influence the challenges and future of mental health care? (please name three)
D. How likely is it that the 'social' will become less important in the science and practice of mental health care in the next 20 years? (from 0: very unlikely to 10: very likely) – Please explain your response
E. How likely is it that the 'social' will become more important in the science and practice of mental health care in the next 20 years? (from 0: very unlikely to 10: very likely) – Please explain your response
F. What will be the most important tasks for research on the 'social' in mental health care in the next 20 years? (please name three)
G. What may be the most important challenges regarding the 'social' in the practice of mental health care in the next 20 years? (please name three)

H. Overall, how will the role of the 'social' change in the science and practice of mental health care of mental health care in the next 20 years?
I. Any other comments?

The online survey can be found at: **https://www.surveymonkey.net/r/Preview/?sm=Z1A_2BISbA0WKIboy9qh9aA2hNkdPEnQgLpi5iCWO0pw8_3D**

The answers were analysed through content analysis by two raters (Giacco and Hadridge) identifying recurrent themes which could be described under 'instabilities' and 'drivers for change'. The findings of the survey informed the work of the expert workshop.
We received and analysed 49 complete responses, from 16 different countries (Austria, Belarus, France, Germany, Italy, Norway, Portugal, Romania, Spain, Switzerland, Turkey, Ukraine, United Kingdom; and from outside Europe Japan, Morocco, United States). The respondents were psychiatrists (n=32), psychologists (11), social scientists (4), and mental health nurses (2). Twenty-one participants were in a fully academic or editorial post, 11 in a fully clinical post, and 17 in a joint clinical and academic post.

Workshop

We (DG, PH and SP) organised a two-day workshop in London. Experts were all from Europe and purposively selected to ensure that attendees included people with relevant clinical or academic backgrounds, at different stages of their career, of different professional constituencies (psychiatrists, psychologists, social scientists), with different current roles (including full-time and part-time clinician, researcher, representative of professional body, journal editor, service manager), and with different degrees of allegiance to conventional social psychiatry.

All 18 invited experts attended the workshop. They were from seven countries; i.e. Austria, Croatia, Denmark, France, Germany, Italy, United Kingdom (see list of authors and acknowledgements).
The workshop started with a consideration of the survey results and a brainstorming discussion to specify and complement instabilities and drivers for change as identified in the survey. Subsequently, the group discussed and identified overall titles of different scenarios. The participants were then split into four working groups, each working on crafting one specific narrative scenario. Participants attended working groups based on their interests in and preference for a scenario. The workshop was chaired by a professional facilitator (Hadridge) who facilitated previous projects using a similar methodology to develop future scenarios for academic medicine and scientific publishing.[1-2] When crafting the scenarios, participants were instructed to provide a brief overall description and consider the implications for research, practice of care, and training of professionals. The scenarios were then clarified, specified and refined in plenary sessions of the workshop, and by further analysis following the workshop, which was undertaken by Giacco, Priebe and Hadridge and

reviewed by all authors. The survey questions and a summary of the main characteristics of the scenarios and of their implications for mental health care, research, practices and training are presented below.

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Summary of scenarios

	Patient controlled service	Modifying social contexts	Virtual mental health care	Partners to the poor
Description	Mental health care would be patient-led and provided without coercion	Interventions would modify the social context of individuals to improve their mental health	Mental health care would be provided via online tools and become virtual	Access to holistic health care would be based on social disadvantage
Practice	Services would be planned and controlled by patients; professionals as advocates for patients' human rights and assistants of patients; no coercive measures	Social interventions would be under the remit of mental health care; data collection and monitoring of social relations of large groups of people; on going and challenging consultation with stakeholders	Patients would shape their virtual professionals; software development based on best available evidence and patient demand; face-to-face care only in emergency cases	There would be co-location of physical, mental and social services; focus on holistic and generic interventions; advocacy to reduce social disadvantage
Research	Based on patient lived experience and on involvement of service users and their relatives/friends	Development of theories, interventions and methods for evaluation; working in partnership with social scientists and other experts of social behaviours	Based on automatic data collection on intervention and outcomes as part of the software; cycles of quality improvement	Erosion of the boundaries between health care specialties, primary focus on understanding how the social disadvantage affects health
Training	Professionals would be trained in assisting patients to achieve their own goals and advocate for their human rights	Social theories of mental health would be a main focus of training. Professionals would learn about influencing communities, implementing social interventions, and assessing change in social relationships	Professional might be trained in supervising virtual contacts and helping the patients navigating the system	Generic and holistic training would be provided to all professionals with less focus on specialised knowledge and skills